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Kimberly Topper,
Center for Drug Evaluation & Research
Food and Drug Administration
5600 Fishers Lane,
Rockville, Maryland 20857

July 18, 2001

Re: Medical Use of Opiod analgesic and various patient populations

Dear Ms. Topper:

I am writing to voice my opinion on the use of slow release narcotics in patients with chronic non-malignant pain. My practice has migrated towards a pain management practice with a high percentage of patients suffering chronic non-malignant pain over the last 5 years. After starting as a general practitioner working in a multi-disciplinary clinic with physical therapists, chiropractors, osteopathic physicians, I became aware of the movement towards the use of such medications as MS Contin and Oxycontin for those patients where everything else had been tried without success. Since then, I have seen hundreds of patients "get their life back", with the use of the slow release medications. I have found, in many cases, I was able to motivate patients to return to work that had been off work for as long as 5 years, even when independent medical examiners said they would never work again. I have been able to motivate patients that had been in chronic low back pain with status post 2 surgeries to motivate themselves to exercise and reduce weight up to 75 pounds and maintain it, greatly increasing their functional capacities. We find, many times, the slow release narcotics are needed to allow patients to progress into therapeutic exercise and return to work. We find very little complications in the way of accidents related to sedative side effects of the narcotics once they are on a stable dose.

I have also witnessed and been on the front line related to the abuse of the slow release narcotics such as Oxycontin, MS Contin, Methadone and Duragesic patches. I, along with the local pain society that formed approximately 2 years ago in the Dayton, Ohio area, have constantly worked to adjust our techniques of detecting the diverters, true addicts, and fraud within our clinic. Formal pill counts, serum drug screens, urine drug screens, and detailed drug contracts are a regular part of our practice in dealing with this pain population. We regularly send patients to addictionologists for evaluation and treatment. We believe that we are doing a good job in "weeding out" the diverters and abusers and will continue to improve our ability to do so as we have become more aware of the problem over the last couple of years. It is my opinion that there has always been a problem. When I started in pain management 5 years ago, it seemed that all patients were on Vicodin, (extra strength) and Soma and I was aware of trafficking in the community with these medications. I believe that it is the same crowd, the same patient population that moved into the abuse and diversion of Oxycontin. I believe that it is simply a more powerful tool and that they are

getting "burned" by fooling with a medication of a high potency in, at times, narcotic naïve abusers.

In relatiion to credentialing for those who might, in the future, be allowed to prescribe pain medications for chronic non-malignant pain, I believe it is important that any physician or doctor of osteopathic medicine be able to demonstrate that they have had special training in the issues related to non-malignant pain and slow release narcotics. In my case, I am not an anesthesiologist. I had training in internal medicine and then went through training with the American Academy of Pain Management and received an alternative board certificatioin. In my yearly conferences we discussed the issues related to slow release narcotics. I have also attended the Ohio State Medical Association's presentation, approximately 3 or 4 years ago, on the use of slow release narcotics. I have kept abreast of the State Medical Boards regulations requiring certain steps be taken in the case of the use of slow release narcotics for chronic non-malignant pain. Therefore, I would oppose the limitation of the use of these medicines for non-malignant pain to anesthesiologists or those fellowship trained in pain medicine. I certainly believe that, as a "Level 1 Pain Management Specialist", I am providing a valuable service. I have learned when it is time to send my patients on to a Level 2 or 3 Pain Management Specialist. 98% of patients that present to my office on referral with complicated conditions such as chronic complex regional pain syndrome or failed back syndrome, are benefited through the use of basic injection techniques, specialized electric stimulation and electronic nerve blocks, strengthening programs, and the use of slow release narcotics and other adjuvant pain medications that I provide. Many times I am able to improve their functioning and return them to work without further surgery and without the need for referral to costly advanced pain managed techniques.

I appreciate the opportunity to provide opinions.

Good luck with this issue.

Sincerely,

John P. Moore III, M.D.
Dayton Pain & Preventive Medicine, LTD.
JPM/mh